James C. Catt
D.M.D
Family & Cosmetic Dentistry

RECORDS RELEASE AUTHORIZATION:

Doctor/Hospital: _____

Address: _____

_____

I hereby authorize and request you to release to Dr. James Catt, D.M.D. All pertinent dental records, perio charting and x-rays in your possession that concern my dental history and/or treatment at your facility. I hereby release Dr. _____ from any liability related to the disclosure of my protected health information.

*Please email films to grin@roguevalleydentist.com

Date of last cleaning: _____ Type of Cleaning: _____

Date of FMX or Pano: _____ Date of RPC(S): _____

Date of BW: _____ Date of Exam: _____

Signature: _____ Date: _____
Patient or Authorized Person

_____
Please Print Patients Name

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